Bemidji Area Beneficiary Access Workgroup

# EXECUTIVE REPORT

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### I. PURPOSE

The purpose of this report is to share the knowledge and experience of the Bemidji Area Beneficiary Access Workgroup (BAW) regarding beneficiary access/eligibility issues and workgroup members hope that this report will serve as a catalyst in the process of resolving important questions. Through much hard work, brainstorming, and long discussions, our workgroup has studied the increasingly more common problem of who is being served by the Indian Health Service (IHS), tribal health programs, and urban programs (I/T/U) in the area.

The workgroup coined the phrase "beneficiary access" as the term of choice when dealing with beneficiary access/eligibility issues because accessing services has become the real problem due to a persistent lack of funding that has resulted in tribes and /or IHS seriously diluting the quality and availability of services. Both the IHS and tribes are confronted with the unfortunate problem and challenge of serving an ever-expanding population of eligible beneficiaries with what appears to be an ever-shrinking portion of federal dollars. The increased pressure on budgets has prompted differing responses amongst tribes, and, as our workgroup progressed, it became clear that not all tribes agree with the IHS on the interpretation of the federal regulations defining an "eligible beneficiary." The Bemidji Area Office (BAO) has become increasingly aware of the variability in tribal eligibility policies.

In this document, the Bemidji Area Beneficiary Access Workgroup has provided background information, made recommendations, and requested immediate action from Indian Health Service Headquarters (HQ). We hope that this report will aid HQ in dealing with this problem on a national level and help other IHS Areas deal with the beneficiary access problem without them having to duplicate our effort. Below we describe the composition of the group, the theory behind the composition, the process followed by the group, and the findings of the workgroup.

### II. INTRODUCTION

The Code of Federal Regulations defines who is eligible to receive the health care services provided by the Indian Health Service. The IHS interprets the regulations in a broad way. The IHS policy provides that any person who is a federally recognized tribal member or descendent who presents him/herself at an IHS facility or a facility operated under a tribal Title I Self – Determination contract or Title III Self – Governance compact shall have access to health care services. Some tribes have adopted the same broad interpretation as the IHS. On the other hand, those tribes not sharing IHS's interpretation of the regulations would like to see this matter addressed jointly by the agency and tribes. Beneficiary Access Workgroup members are concerned that this matter will end up in court rather than settled through tribal consultation and legislative action.

Situations arising and exacerbating this issue in the Bemidji Area include: a large influx of Indian people returning to reservations and/or tribe's contract health service delivery area (CHSDA);

Indians now eligible and utilizing facilities and services for the first time because of the high cost

of health care alternatives; and the close geographic proximity of tribes to one another which increases the likelihood of patients seeking care from multiple tribal health care programs.

Federal funding has become more severely inadequate than ever. While Congress has voted for funding increases over the past few years, these increases have not kept pace with the annual increases in the cost of medical goods and services, nor the cost of caring for a steadily increasing Indian beneficiary population (newly recognized tribes and population growth). Additionally, sufficient levels of Congressional funding for newly reaffirmed tribes (five new tribes in the last six years for the Bemidji Area) has not accompanied the Congressional recognition of these tribes. Simply, more people are using IHS and tribal health care services and Congressional funding is not increasing to meet the demand. The result is insufficient funds to serve more people at higher costs.

The eligibility issue is really one of beneficiary access and tribal sovereignty. The basic rights of tribes to determine who is or is not a member of their communities is central to any discussion of eligibility. No matter how much money Congress appropriated, eligibility remains an issue of concern if tribes are not allowed to exercise their sovereign rights. Unfortunately, Congress has not appropriated adequate funds for care and so the issue of beneficiary access/eligibility has only intensified in recent years.

## III. ESTABLISHMENT OF THE BEMIDJI AREA BENEFICIARY ACCESS WORKGROUP

The Bemidji Area Office took an important first step towards addressing this increasing problem by holding an initial informational "Eligibility Roundtable" with key federal administrators on February 5, 1999 in Minneapolis, Minnesota to identify major issues and develop a process for obtaining answers. The decision to form a Bemidji Area Beneficiary Access Workgroup resulted from this meeting.

The workgroup consisted of twenty-one members as follows: representatives from ten tribal programs; three IHS Service Units; one urban program; five BAO staff; and two Office of the General Counsel attorneys (one from HQ and one from Region V). The BAW was coordinated and facilitated by Dr. Dawn Wyllie, BAO Chief Medical Officer/Deputy Area Director. Each participant came with a unique perspective. The reason for having a diverse membership within the workgroup was to bring together people with different experiences to more thoroughly explore the depth and complexity of the beneficiary access/eligibility issues in the Bemidji Area. All of the members agreed that although consensus may not be reached on every item, all members would work collaboratively to address the beneficiary access/eligibility issues, consider possible solutions, and make recommendations to IHS HO.

### IV. BACKGROUND

The federal government's obligation to provide health care services to Indians is defined by statute and regulation, and constrained by Congressional appropriations. The basis of beneficiary access problems is that health care services should be provided to eligible beneficiaries but funding is not adequate to provide the necessary health care. BAO tribes are funded at approximately 30%-40% of the "level of need" by the federal government, representing the lowest figure of any IHS Area. This percentage resulted from the 1999 IHS national "Level of Need Funded Study" that was based upon many factors, including user population data. In order to improve health care for their membership, some tribes must provide supplemental funds. The Indian Health Service recognizes that tribal assets belong to the tribe and there is no obligation to provide services to non-members out of tribal dollars.

There are tribes that have chosen to define community membership differently than the IHS to preserve the integrity of their health care delivery system. Consequently, they are not serving some individuals whom IHS would serve. And, tribes are asking why they should use their resources to pay for health care for people whom they do not consider members of their community. Moreover, many tribes are questioning why they should provide services to individuals who are not members of their community when the IHS official user population counts only eligible Indians who live within the tribe's service delivery area. Indians who access direct care and live outside a service delivery area are not counted in the headquarters official user population. Currently, over half (53%) of the total 243 counties in the Bemidji Area are non-CHSDA counties (Michigan 37%, Minnesota 70%, Wisconsin 51% respectively).

The February 1999 "Eligibility Roundtable" meeting was held because an Area tribe had begun limiting services to only tribal members and their descendents that lived within their CHSDA/ service delivery area. This action resulted in approximately 150 patients living outside the tribe's CHSDA/service delivery area, who had formerly utilized services, becoming no longer eligible for direct care at the tribal facility. The Bemidji Area Office was contacted by an affected patient to inform staff of this change and to request action. And, about the same time, another Area tribe changed their eligibility policy to provide Contract Health Service (CHS) only to members living on their reservation. Thus, 100+ non-tribal member Indian patients were no longer served for CHS by this tribe. These situations demonstrate two types of beneficiary access/eligibility challenges occurring in the Bemidji Area that initiated our workgroup process.

Other tribes have limited access to try to protect their scarce resources and maintain the quality of care their patients have come to expect. The IHS must determine what its response should be toward patients deemed eligible by IHS who are not being served by the tribe, and what its response should be toward the tribe that has accepted IHS resources to serve its community members.

Beneficiary access issues also affect urban Indian organizations because many Indians are seeking services at urban health care facilities when they visit, reside part-time, or relocate to urban centers within the Bemidji Area. Sometimes, an IHS and/or a tribal

facility and an urban program will share in the care of a patient. Urban programs are funded under the Indian Health Care Improvement Act, P.L. 94-437 (Title V- Health Services for Urban Indians) and different regulations apply (42 C.F.R.§§ 36.350 – 36.353). Like tribes, urban programs also question why they should use their limited resources to pay for health care for visitors, transient patients, or other Indian people who do not reside within their geographic area. And, like some tribes, at times urban programs have restricted health care access to certain services for Indians living outside their urban region.

These issues will not be resolved as long as there remains a question on who is actually eligible (and where) for health care services. A system to identify specifically who is eligible and a system to provide appropriate funding to serve all eligible beneficiaries must be devised.

When the BAW began, many tribal representatives wanted clarification on the parameters of the federal statutes and regulations. They wanted to know where tribes had flexibility in determining their service population and in the types of services that were provided. They wanted to know how their sovereignty would be affected by IHS policies and directives, such as the IHS Director's January 10, 2000 letter. The problems mentioned and discussed at the BAW meetings included: differences between Title I, Title III, and direct service tribes; urban programs; Indians that lived on or near a reservation; Indians living inside or outside of a CHSDA; Indians living on trust land; tribal descendency; dilution of the quality and availability of health care; CHS and direct care; budgeting tribal money with IHS money; third party revenue; changing demographics; base funding calculations; user populations; user count; tribal shares of IHS HQ and BAO, etc.

### V. BENEFICIARY ACCESS WORKGROUP MEETINGS

### A. MEETINGS - INTRODUCTION

The Beneficiary Access Workgroup met four times over the course of a one-year period. The meetings were held on April 29, 1999, June 3, 1999, October 12, 1999, and April 3, 2000 in Minnesota. Several teleconferences were also held along the way.

The initial charge by Dr. Kathleen Annette, Bemidji Area Director, to the BAW was to:

- 1. Identify the issues related to health care and beneficiary access,
- 2. Discuss impacts of changing access requirements,
- 3. Gather possible recommendations on how to address the issues that will impact or define access in the future.

The BAW members feel that, in the past, the IHS has not acted uniformly in addressing the tribes' request for clarification on various eligibility issues and that much more work needs to be done in this area.

The BAW found that the group was able to identify and address some of the primary issues involved in this matter, however, several related components/secondary issues were unable to be fully explored. Consensus was not the goal or intention of the workgroup. The main goal of our workgroup was to extrapolate the issues and demonstrate the complexity of the beneficiary access problem, enabling the IHS and tribal programs to start addressing this entire matter using some type of process.

### B. ISSUES RELATED TO HEALTH CARE BENEFICIARY ACCESS

#### 1. DIRECT CARE ISSUES

The members of the BAW quickly realized that direct and contract health services had to be dealt with separately. The Indian Self-Determination and Education Assistance Act, P.L. 93-638 (Sec. 105 (g)) requires that tribes act "in accordance with the terms of the contract or grant and applicable rules and regulations of the appropriate Secretary."

The Indian Health Care Improvement Act, P.L. 94-437, codifies the government's responsibility to Indian people with regard to health care (see e.g., Declaration of Health Objectives § 3). The implementation of federal regulations addresses which Indian people are eligible for direct care (42 C.F.R. § 36.12 (1986)) and who is eligible for contract health services (42 C.F.R. § 36.23 (1986)). The BAW members believe that the regulations are broadly written, which may explain why some tribes differ from the IHS in their interpretation of these regulations.

This situation has therefore contributed to differing interpretations of eligibility. The IHS has interpreted this regulation broadly to mean that every person of Indian descent is eligible to receive care. This position was clearly outlined in the Director of IHS's "Dear Tribal Leader" letter dated January 10, 2000 and is often referred to as the "Open Door Policy." Some tribes believe that the IHS is, in fact, paternalistically claiming the right to make such intimate tribal decisions regarding who belongs to their communities.

These tribes further believe that the IHS interpretation is erroneous and contrary to federal law and Indian policy, and that 42 C.F.R. Part 36 (1986) must be interpreted harmoniously with the eligibility provisions of the IHCIA in order to preserve its constitutionality and congressional intent. They also believe that the IHS interpretation fundamentally interferes with tribal self-government by attempting to replace the clear membership based eligibility standard of the IHCIA with a vague federal entitlement which effectively takes health care services away from tribal members and gives those services to non-tribal community member Indians. Moreover, these tribes are concerned that forcing tribes to provide services to non-tribal community members without providing additional funds constitutes an impermissible unfunded mandate.

The IHS must consider how the quality of care at their facilities as well as at tribal and urban health facilities will be further impacted if they continue to serve individuals not

considered eligible for services by local tribes. Unfortunately, both the IHS and tribal facilities are becoming increasingly overcrowded. The BAW believes that while the IHS may consider decreasing funds for those tribes who do not practice the "Open Door Policy," it must be careful not to charge an already volatile atmosphere with resentment unless it has clear Congressional direction. Realistically, it is economically quite difficult to run a local health care facility and budget for the entire Indian community conceived of under the "Open Door Policy."

It is the position of workgroup members that it is in the best interests of both IHS and tribes to take a proactive stance in addressing this issue rather than allowing less than optimal solutions that may result, such as judicial rulings.

### 2. CONTRACT HEALTH SERVICES

CHS services, on the other hand, are limited to eligible Indians living within a Contract Health Service Delivery Area and to eligible Indians living on the specific reservation (42 C.F.R. § 36.23 (1986)). The following scenarios illustrate the complexity of CHS care. Some tribes would like to serve tribal members located outside the CHSDA (such as those residing on trust land), but the regulations do not permit them to do so. Some CHSDA's are ill defined: they do not include some nearby counties where Indian people who need services live; or, in some cases, tribes share CHSDAs. Some tribes are frustrated that they cannot serve their tribal members, but are required to serve members of other tribes that live within the CHSDA and/or the reservation boundaries. One tribe has chosen to provide CHS only for their tribally enrolled members and recognized descendents living on their reservation, which necessitated a mutually agreed upon solution between the tribe and IHS to serve the Indians affected by the tribe's decision.

### C. IMPACTS OF CHANGING ACCESS REQUIREMENTS

The impacts of changing access requirements are far reaching and affect I/T/U programs, tribal governments, and individual Indian people who are tribal members and descendents of enrolled members. While some broad inferences to the impacts are interspersed throughout this document, it was beyond the scope of our workgroup to fully explore this aspect. Certainly, the quality and types of health care services, the continuity of care, timely and reasonable geographic accessibility to primary care, and health care referral patterns are all examples of areas of care that are impacted by beneficiary access/eligibility decisions. It is hoped that a national beneficiary access workgroup will conduct an in-depth analysis of existing and potential impacts.

### D. BENEFICIARY ACCESS WORKGROUP RECOMMENDATIONS

This report emphasizes the complexity of issues surrounding beneficiary access/eligibility. The core issues are funding and tribal sovereignty. As I/T/U programs are experiencing this severely inadequate level of funding and facing an increasing Indian population in need of health care, the situation has unfortunately led to health services being compromised both quantitatively and qualitatively. This has necessitated some tribes taking different measures to try and maintain their local health care delivery systems. The IHS operated facilities are impacted by the same fiscal constraints and Indian population concerns that tribal and urban programs are

dealing with, and must follow the "Open Door Policy." Tribal programs are struggling to be fair, yet see a primary responsibility to their own members. And, the urban programs have patients that may no longer be able to receive and/or augment their health care by trips to reservation-based facilities, thus, placing a greater burden on their already greatly under-funded urban Indian programs.

The following recommendations are respectfully submitted with acknowledgement that, as I/T/U partners, we must collaborate on beneficiary access/eligibility issues within the context of tribal sovereignty:

- 1. Immediately organize a meeting with tribes to form a national beneficiary access/eligibility workgroup to study and discuss the issues, recommend solutions, and to develop a tribal consultation process. This consultation process would be used when considering the implementation of any additional eligibility policy and/or the enforcement of existing policies (especially involving declinations/ratifications) and before taking any action(s).
- 2. Develop a means of gathering information to identify unserved Indians and reasons why they do not have, or take advantage of, access to health care. Also, develop a way to determine the impact of serving an increasing Indian population on I/T/U health care programs.
- 3. Define "need." Fund tribes to provide health care services to the Indian population that they serve, including new tribes as they are recognized and expanded Contract Health Service Delivery Areas, at their full level of need requirements for program operation and facilities. Fund subsequent annual increases sufficient to cover service population growth.
- 4. For Title I contracts and Title III compacts, establish standard national methodologies through tribal consultation for fairly determining the amount of partial declinations or ratifications involving a tribe's partial assumption of CHS and/or direct care services. Include a process and outline the alternatives to/options for such action.
- 5. Revise the current methodology for calculating user population counts to accurately reflect the fact that tribes provide direct care to Indians living outside their service delivery area.

### VI. CONCLUSION

After several meetings and teleconference calls over a year's time frame, the Beneficiary Access Workgroup members have become very familiar with the issues surrounding beneficiary access/eligibility. We realize that these problems cannot be solved overnight. Still, we hope that the Indian Health Service, tribes, and urban programs can collaboratively make progress before the situation further escalates. This matter requires immediate attention.

This executive report has been sent to all I/T/U programs in the Bemidji Area for their comments. All of their written correspondence will be included as a section in the addendum of this report along with the following reference materials:

- 1. 42 C.F.R. Part 36 (1986) (Sec § 36.12 for direct services and § 36.23 for contract health services); 42 C.F.R Part 36 (1990).
- 2. Contracts Under the Indian Self-Determination and Education Assistance Act (Subpart L Appeals), 61 Fed. Reg. 32,526 32,529 (1996) (codified at 25 C.F.R. §§ 900.150 900.177).
- 3. Indian Health Care Improvement Act, P.L. 94-437, As Amended Through October 19, 1996 (Title VIII Miscellaneous (Sec. 813 Health Services for Ineligible Persons)).
- 4. Indian Health Service Director's January 10, 2000 "Dear Tribal Leader" letter
- 5. Bemidji Area Indian Health Service Director's February 29, 2000 letter to John Seppanen, Health Director, Keweenaw Bay Indian Community.
- 6. IHS Handout What are Contract Health Services (CHS)?
- 7. IHS Facts Sheet How User Population Counts Are Determined (For HQ Shares)
- 8. IHS Flow Sheet Are Registrants with Tribal Codes 000, 997, 998, or 999 Counted as "Indians" in User Population Counts with Attachments (Blood Quantum Codes, Classification Codes)
- 9. Matrix Eligibility for Fond du Lac Services

Once this correspondence has been received, this entire document along with I/T/U comments will be forwarded to Dr. Michael Trujillo, Director of the Indian Health Service.

Minutes from the Beneficiary Access Workgroup meetings are available upon request by contacting Dr. Dawn Wyllie via fax 218/759-3512 or email: <a href="mailto:dawn.wyllie@mail.ihs.gov">dawn.wyllie@mail.ihs.gov</a>.